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ABSTRACT

Although illness is often linked to low morale among the elderly, most persons cope with and adjust to illness. A hypothesized model of favorable family response to illness suggests the importance of resources as mediators to avoid crisis. To test this model, 53 older patients with lung disease and their spouses were interviewed about individual and family adjustment. Fourteen categories of resource items were included, centering on health, social support, finances, and coping. Results showed that although most respondents were in poor health, they appeared well or fairly well adapted. Good health, cognitive coping, formal supports, greater financial savings, and spouse employment were predictors of better adaptations. Informal support systems were predictive of poorer adaptation, which may reflect the reality of severe illness and greater disability. The investigation of crisis with a view to resources has policy as well as research implications, suggesting the need for improving the resources of the aged to enable better psychosocial outcomes. (JAC)

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OLDER FAMILIES AND CHRONIC DISABLING ILLNESS: PREDICTING BETTER ADAPTATION

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Introduction

Chronic illness, one of the most common and troublesome stressors confronted at later life afflects more than 8 of 10 older persons (National Center for Health Statistics, 1981). There are many sequellae of illness among the elderly with poor health and low morale frequently being linked (George and Bearon, 1980; Lee, 1978; Larson, 1978). Health problems of the aged also affect family members, notably caretakers (Cantor, 1982; Fengler and Goodrich, 1979; Lurie, 1981; Paykel, 1978; Troll,et al, 1979; Zarit, et al., 1980). However, not all families fare poorly. Although empirical findings are often inconsistent (Brown, et al., 1982), most persons cope with and adjust to illness (Moos, 1977).

One theoretical formulation supportive of this contention is based upon a family sociology framework and posits that stressors, including illness, need not result in family crises when resources intervene (Burr, 1973; Hill, 1949; McCubbin and Patterson, 1981). This paper, reporting on patient and spouse adaptation to serious illness at late life is an attempt to confirm the mediating role of resources. It was hypothesized that the stressor event-crisis linkage would be mitigated by resources in that certain resources could facilitate illness adaptation. The following figure indicates the model tested:

Figure 1. Favorable Family Illness Response

STRESSOR EVENT	+	MEDIATORS	⟶	CRISIS AVOIDANCE
(serious chronic illness)		(resources)		(illness adaptation)

Methodology

The study reported is part of a larger research among ninety-three families facing chronic lung disease. Fifty-three patients and spouses age 65 and over were represented among the sample provided by pulmonary clinics, private physicians and the American Lung Association. Interviews of respondents were conducted in homes, pulmonary clinics and patient education group meetings. Spouses were interviewed separately from patients. Characteristics of the older respondents were: 56% male, 44% female; 68% with incomes under $20,000 yearly; 55% high school graduates or better.

The lung ailments considered (emphysema, chronic bronchitis, asthma and bronchiectasis) represent the category Chronic Obstructive Pulmonary Disease (COPD). It is the fifth most frequent cause of activity limitation of the elderly (National Center for Health Statistics, 1981).

COPD, particularly emphysema, the most serious disease in the category, is characterized by breathing difficulty, low energy levels, and frequent usage of medication. Emphysema is a progressive condition and at later stages patients are quite disabled. They need to learn techniques that facilitate breathing and are often reliant on oxygen therapy.

The interviews were addressed toward individual and family response to COPD and consisted of administering a questionnaire both open ended and structured.

Fourteen categories of resource items were included in the questionnaire centering on health, social support, finances and coping. The variables, derived from medical sociology and aging literature are presented in Table 1. Crisis avoidance, represented by personal and familial adaptation to the illness was measured by a three item Adaptation Scale (items in Table 1). All inter-item correlations of this scale proved significant to $p < .001$.

Table 1 about here

Results

Analysis of health data indicated that a large majority of the respondents over age 65 had serious health problems. As presented in Table 2, 73% had emphysema alone or in combination with another lung disease. Almost three-fourths were severely limited according to U.S. Public Health Service criteria (1971). During the 6 months prior to the interview, 29% had been hospitalized for at least one week. Frequent ambulatory care was common with almost four of ten (36%) visiting physicians at least once monthly.

Table 2 about here

Despite poor health the majority did not have serious difficulty adapting to COPD and its limitations. As proposed by Moos (1977) most appeared well or fairly well adapted, exhibiting mean Adaptation Scale scores of 7.3 (standard deviation 2.1), of a possible 10.

To test the hypothesis that the adaptation shown by respondents was promoted by resources, fourteen resource items considered to be crisis-retarding were analyzed. Multiple regression analysis, the major statistical evaluation, indicated that resources predicted illness adaptation and accounted for 20% of the variance in the dependent variable ($R=.44$, $R^2=.20$). However, these findings, which are supportive of the hypothesis require further elaboration. The fourteen resources differed considerably in their effects on adaptation. As figure 2 will show, some resources were considerably more powerful than others. Perhaps more relevant, not all were adaptation promoters. Whereas five enhanced adaptation and four had minimal effect another five resources were adaptation deterrents. Most predictive of better adaptation were: 1) good health, 2) cognitive coping, 3) formal supports, 4) greater savings, and 5) spouse employment. Conversely, respondents

least likely to adapt well had higher levels of insurance and income, greater illness knowledge and more spouse and family support.

Figure 2 about here

With respect to these findings, the next figure presents the model of favorable family response tested in this study. Resources which proved to be the most powerful mediators of illness crises are indicated.

Figure 3. Chronic Lung Disease Adaptation (older families)

STRESSOR EVENT	+	MEDIATORS ⟶	CRISIS AVOIDANCE
(serious chronic illness)		(resources) -Good health -Cognitive coping -Health agencies (formal support) -Savings -Spouse employment	(illness adaptation)

Discussion and Summary

Evidence from this study supports the hypothesis and its theoretical base that older patients and spouses facing chronic lung disease fared better psychosocially if resources mitigated the situation. However, resources were not uniformly effective in that some enhanced favorable response while others retarded it or were negligible in effect. While these findings may relate to characterisitics of the resources which were investigated, explanation may also be provided by characteristics of the illness itself.

The study showed that the most important predictors of favorable response were health and cognitive coping while informal support systems were predictive of poorer adaptation. That those who adapted best were healthier and defined the illness in more positive terms is quite consistent with gerontological literature associating health and morale. Also reported is that healthier

aged receive less assistance and are less reliant on informal support. Those who have observed chronic lung patients in deteriorating stages of their diseases recognize the inability to care for self. There is physical limitation, dependency, and illness symptoms associated with severe breathing problems. Oxygen therapy and confinement to wheelchairs are common occurrences among emphysemics with debilitated health. Spouses, children and others are called upon. Therefore, these findings indicating poorest illness adaptation among patients and spouses with the greatest degree of informal support may be reflecting the reality of severe illness among older persons. The downward trajectory of many chronic diseases produces a great need for assistance. Yet, since failing health also yields low morale and poor illness adaptation, social support, although important, may not reverse the health-morale linkage.

In addition to the contribution of health to better adaptation was the beneficial effect of cognitive coping style. This particular resource, the second best predictor of adaptation, concerned favorable perception of the illness. Again, health may be the key factor in that negative illness perceptions may be more typically observed among persons with the greatest illness severity.

Other predictors of good adaptation were level of savings, employment of one's spouse, and formal support offered by health agencies. The contribution of all three may relate to the sense of security they afford. Persons facing chronic disabling disease who feel more secure may adapt better.

Other researchers may wish to pursue the resource framework among populations larger in size and with different illnesses. In view of these findings it would be useful to test a number of items simultaneously as done herein,

but also to control for illness severity. This would enable social support to be better evaluated in health problems of the aged.

In summary, this study demonstrated that elderly patients and their spouses generally adapt well to serious chronic disease, but it also confirmed the importance of resources. The aged are aided in their adaptation by crisis-retarding resources, notably coping style, health, and formal supports and some economically relevant items. The investigation of crisis regarding resources appears to have policy, as well as research implications in that "shoring up" resource poor aged may enable them to have better psychosocial outcomes.

Table 1

A. Resource Variables

1. Informal social support (spouse)
2. Informal social support (kinship - children, family)
3. Formal social support (health, social agencies)
4. Formal social support (religious agencies)
5. Health related (health status)
6. Health related (illness knowledge)
7. Health related (treatment compliance)
8. Health related (physician interaction)
9. Coping (cognitive-illness perception)
10. Economically related (income)
11. Economically related (savings)
12. Economically related (employment)
13. Economically related (spouse employment)
14. Economically related (insurance)

B. Illness Adaptation Variables

1. Personal adjustment to illness
2. Satisfaction with tasks, responsibilities since inception of illness
3. Trying to lead normal family life despite illness

Table 2

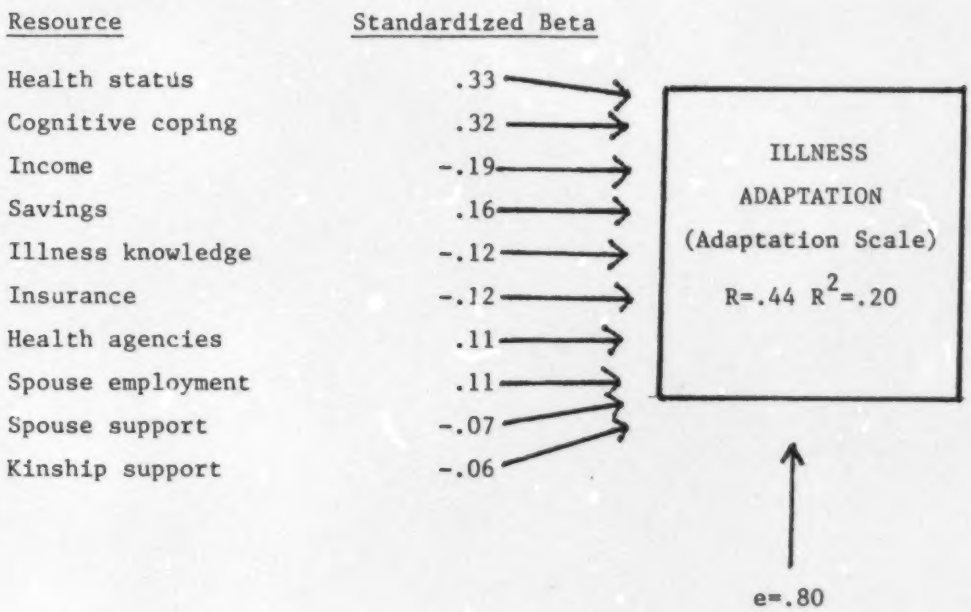
Health Characteristics of Sample (N=53)

Lung Disease	
Emphysema	49%
Asthma	18%
Emphysema and another lung condition	24%
Didn't know name of condition	9%
Duration of Illness	
Less than 1 year	4%
1-3 years	64%
4 or more years	31%
Degree of Disability[a]	
None	4%
Some - major activity only	2%
Some - all activities	18%
Severely - all activities	73%
Hospitalization Past 6 Months	
None	49%
1-6 days	22%
7-29 days	16%
30 or more days	13%
Physician Visits	
Several times yearly	65%
Monthly	27%
Weekly	9%

[a]According to criteria of U.S. Publis Health Service, 1971

Figure 2. Resource - Adaptation Relationships

Resources with direct effects > .05



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